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Vaccine-preventable diseases and immunization: realizing the full potential of the European Vaccine Action Plan 2015–2020

In 2014, through extensive consultations with Member States and partners, the European Vaccine Action Plan 2015–2020 (EVAP) (document EUR/RC64/15 Rev.1) was drafted to complement, regionally interpret and adapt the Global Vaccine Action Plan 2011–2020 in harmony with Health 2020 and other key health strategies and policies in the WHO European Region. EVAP was adopted by the WHO Regional Committee for Europe at its 64th session (RC64) in September 2014, in resolution EUR/RC64/R5.

A midterm review of EVAP was carried out by the WHO Regional Office for Europe and the final report of the review in its entirety is being submitted to RC68 as a background document. The midterm review highlights the achievements in the WHO European Region from 2015 to 2017, and identifies further efforts that will be required to maintain the momentum and leverage the full potential of EVAP. It reaffirms the fact that immunization is one of the most cost-effective interventions against the threat of emerging diseases and emphasizes how immunization programme performance significantly contributes to the attainment of the Sustainable Development Goals and universal health coverage in the Region.

Even with the Region maintaining its polio-free status and an increasing number of Member States interrupting the endemic transmission of measles and/or rubella since 2014, the midterm review outlines the importance of and the need for political commitment, adequate resource allocation and continued advocacy to achieve the agreed targets, and remaining vigilant in the face of the challenges and threats in the Region. The report highlights the need for the Region to explore new and innovative means of ensuring that vaccine shortages and supply disruptions have a lower impact on immunization programmes. Declining or plateaued trends in vaccination coverage in middle-income countries (MICs) in recent years indicate their inability to sustain programme performance. In addition, MICs, many of which self-procure vaccines and rely solely on their domestic financial resources, face challenges in expanding their immunization programmes through the introduction of new vaccines. The report highlights the need to develop a cohesive strategy to address these challenges faced by MICs. Ultimately, the midterm review report emphasizes the importance of Member States continuing to convey their support for the EVAP goals and, in doing so, expressing their willingness to collaborate to close immunity gaps and to extend the benefits of vaccination equitably across the life course to all individuals in the WHO European Region.

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Background

1. The European Vaccine Action Plan 2015–2020 (EVAP) (document EUR/RC64/15 Rev.1) was adopted by the WHO Regional Committee for Europe at its 64th session (RC64) in September 2014 in resolution EUR/RC64/R5 to complement, regionally interpret and adapt the Global Vaccine Action Plan 2011–2020 in harmony with Health 2020, the European policy framework for health and well-being. By placing health at all ages and reduced inequality at the centre of immunization efforts, EVAP set the WHO European Region on a course that is fully aligned with Sustainable Development Goals (SDGs) 3 and 10.

2. As reflected in the 2030 Agenda for Sustainable Development, much has changed in how we view, measure and promote health both as a product and driver of human development. Throughout the global agenda-setting process, recognition of immunization's important role in helping to achieve the SDGs did not waver. The principle of "leaving no one behind" includes reaching every individual (child or adult) with the vaccinations they need in order to be healthy.

3. It is widely recognized that immunization is one of the "best buys" not only in health but also for sustainable development. If the vision and goals set in EVAP are achieved, a recent analysis suggests that the economic benefits for the period 2011–2020 in the nine middle-income countries (MICs) in the Region[1] would amount to US$ 5 billion, with a return on investment of US$ 5 for every US$ 1 invested.

4. EVAP embodies the principles of equity and empowerment underlying the SDGs. As such, it has already laid important groundwork for achieving the SDGs in the Region.

5. Guided by the vision of "a European Region free of vaccine-preventable diseases, where all countries provide equitable access to high-quality, safe, affordable vaccines and immunization services throughout the life course", EVAP sets a course through a regional vision and goals for immunization and control of vaccine-preventable diseases from 2015 to 2020 and beyond, by defining indicators and targets, and proposing a set of priority actions, for each EVAP objective, taking into account the specific needs and challenges of the Member States in the Region.

6. Six regional goals have been developed in alignment with the Decade of Vaccines and within the context of the WHO European Region:

- Goal 1. Sustain polio-free status
- Goal 2. Eliminate measles and rubella
- Goal 3. Control hepatitis B infection
- Goal 4. Meet regional vaccination coverage targets at all administrative levels
- Goal 5. Make evidence-based decisions about the introduction of new vaccines
- Goal 6. Achieve financial sustainability of national immunization programmes

7. To attain these six regional goals, five objectives incorporating priority action areas and indicators have been developed.

[1] Armenia, Azerbaijan, Georgia, Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan (MICs as per 2013 World Bank income group level).

8. Progress towards achieving both the goals and objectives is monitored within a monitoring and evaluation framework – itself a core component of EVAP.

9. A review was conducted to document the progress made by the Region up to the end of 2017, which represents the mid-point of EVAP's lifespan (2015–2020). The midterm report contains updated information for each of the goals outlined in EVAP on the basis of the most recent figures. The midterm review report used WHO/United Nations Children's Fund estimates of national immunization coverage for the years 2014 to 2016. However, for 2017, the coverage estimates used were those reported by Member States.

10. The midterm report assesses progress towards the goals and objectives against the agreed EVAP targets, objectively reflects key issues in the Region, and proposes operational and strategic interventions to address the priorities and challenges identified by Member States and other relevant stakeholders. The report and the proposed corrective interventions provide an opportunity for all stakeholders in the Region to renew their commitment to the goals of EVAP to ensure that the benefits of immunization do indeed reach people everywhere, thereby contributing towards the SDGs in the Region.

Midterm review methodology

11. In summary, the midterm review assessed data and information for 2015, 2016 and 2017 with 2014 as the base year for the measurement of progress towards the EVAP goals. The monitoring and evaluation framework, including the existing indicators (as defined in EVAP, and the data source reliability for their measurement) were comprehensively assessed in February 2018 by the WHO Regional Office for Europe prior to initiation of the midterm review.

12. The Regional Office commissioned an independent consultant to conduct the review of progress made by Member States on each of the goals and strategic objectives using the indicators outlined in EVAP. The midterm review report contains narratives outlining the progress made towards each of the goals, including a standalone chapter on challenges facing MICs.

13. A working group of the European Technical Advisory Group of Experts (ETAGE) was formed by the ETAGE Chair to oversee the development of the report, review the findings and draft recommendations for Member States.

14. The midterm review report outlines the key findings and conclusions from the midterm review including recommendations to all the stakeholders – which is presented in its entirety as a background document to the Regional Committee for reference purposes.

Midterm review findings

Goal 1: Sustain polio-free status

15. At its 32nd meeting, the Regional Certification Commission (RCC) concluded that, based on the available evidence, there was no wild polio virus transmission in 2017. Although the Region has maintained its polio-free status, there is a need for all Member States to

address the remaining immunity gaps, maintain high-quality surveillance to detect transmission of wild or vaccine-derived polioviruses, be prepared for a timely and robust response to importation of cases, and ensure adequate containment of polioviruses in preparation for global certification and for mitigating potential risks of re-emergence of the virus in the post-certification period.

16. In 2017, three Member States remain categorized as high risk for sustained transmission following importation, primarily due to low population immunity; in addition, two were provisionally categorized as high risk pending further clarification.

17. In addition to the stringent assessment of risk due to programmatic failures and seeking evidence from Member States on their risk mitigation measures in critical areas such as population immunity and disease surveillance, the RCC in 2017 also included the risk-ranking of poliovirus essential facilities (PEFs) in the overall poliomyelitis risk assessment framework to better reflect the risks related to poliovirus containment in the Region.

18. Containment of polioviruses will become an important issue in the Region that will require close monitoring in preparation for global certification and to mitigate risks in the post-certification period. Member States with PEFs in the Region are required to establish national authorities for containment (NACs) to monitor the implementation of containment measures. As of June 2018, 13 Member States in the Region had declared their intent to establish one or more PEFs, including several vaccine manufacturing facilities, critical for polio vaccine production. Nine of these Member States had established NACs; the remainder will need to complete the process to formally establish an NAC.

Goal 2: Eliminate measles and rubella

19. The target for interruption of measles and rubella transmission for > 12 months in all Member States in the Region by 2015 was not met.

20. Based on the reports submitted by the national verification committees, the Regional Verification Commission for measles and rubella (RVC) has concluded that since 2014 an increasing number of Member States in the Region have demonstrated the interruption of endemic measles and rubella transmission.

21. Despite the steady progress in measles and rubella elimination in the Region, the RVC expressed concerns about the quality of the annual reports, with particular reference to surveillance performance making it difficult to assess the interruption of endemic transmission in some Member States. Concerns about the quality and completeness of information on immunization coverage and surveillance data also apply to some of the Member States that have been verified as having eliminated measles and rubella.

22. In 2017, a total of 22 377 (range 1 to 5610) cases of measles were reported from 43 Member States in the Region with a regional incidence of 23.4 per 1 million population (range 0 to 290.6) as of June 2018. Large outbreaks of over 1000 cases were reported from four Member States, namely Greece, Italy, Romania and Ukraine. The total number of rubella cases reported in 2017 was 723, with a regional incidence of 0.78 per 1 million population. The surveillance sensitivity, especially for rubella, varies considerably across the Region.

23. Immunization coverage of ≥ 95% with two appropriately spaced doses of measles-containing vaccines is needed to achieve and sustain measles elimination. While coverage in the Region is generally high, it falls short of the target threshold for both the first and second doses of measles-containing vaccines (MCV1 and MCV2). In 2017, of the 52 Member States which reported coverage with MCV1, 23 had coverage of < 95%, of which the coverage was 90–94% in 14 and below 90% in nine Member States; two Member States had coverage of < 70%. Of the 49 Member States which reported the coverage with MCV2 for 2017, 31 had coverage of < 95%, with 17 of these having coverage of < 90%.

24. The implementation of standardized case-based measles and rubella surveillance remains a challenge in the Region because of the divergent surveillance systems in Member States. Although most Member States in the Region conduct case-based surveillance for measles, as of 2017, nine Member States were still not reporting monthly case-based data to WHO.

25. The availability of measles and rubella genotyping data, together with epidemiological information, are important elements that enable Member States in the Region to distinguish between endemic and import-related transmission. Analysis of the measles case-based data submitted to WHO in 2017 reveals that 94% of samples collected were investigated in a laboratory and that the origin of infection was known in 64% of these positive cases. While the reporting of genomic sequence data for measles has improved in recent years in the Region, the reporting of genomic data for rubella remains low.

Goal 3: Control hepatitis B infection

26. The Action Plan for the Health Sector Response to Viral Hepatitis in the WHO European Region was endorsed by the Regional Committee for Europe at its annual meeting in September 2016 in resolution EUR/RC66/R10. This plan defines hepatitis B immunization targets and priority activities.

27. The Regional Office has developed guidelines for validating the achievement of the regional control targets. These guidelines were developed in collaboration with the ETAGE working group that will also be responsible for reviewing the country reports to validate the achievement of targets.

28. The hepatitis B vaccination policies vary considerably between Member States in the Region. Universal hepatitis B immunization is provided by 49 of 53 Member States (92%) of which 25 implement universal immunization starting at birth, 21 conduct universal vaccination of infants starting at 1–3 months of age, and three implement a universal hepatitis B immunization programme in childhood or adolescence. The four northern European Member States (Denmark, Finland, Iceland and Sweden), where endemicity is very low, do not provide universal childhood or adolescent vaccination, but rely on selective immunization of newborns of hepatitis B carrier mothers and of “high-risk” groups.

29. In 2017, of the 44 Member States which reported coverage for three doses of hepatitis B, 17 had achieved the 2020 target coverage level of ≥ 95%; 32 had achieved the coverage target of ≥ 90% set for 2018 in EVAP; and 12 reported coverage of < 90%.

30. Twenty-five Member States in the Region provide universal newborn vaccination; 14 of these Member States also screen pregnant women and provide immune prophylaxis to infants

born to mothers who are positive for HBsAg. The remaining 28 Member States do not provide universal newborn vaccination, but conduct antenatal screening and immune prophylaxis.

31. Systematic reviews of available data from the Region indicate that nationally representative good-quality seroprevalence data are limited. A systematic review conducted by the European Centre for Disease Prevention and Control was only able to identify studies with low probability of bias from 13 Member States. In another review of data from countries in the Region which are not members of the European Union or the European Free Trade Association, only 21 studies from seven Member States could be identified, of which only four had national or multi-site serosurvey data from the general population.

Goal 4: Meet regional vaccination coverage targets at all administrative levels

32. WHO European Region Member States are committed to further reducing health inequalities through Health 2020 by taking action on the determinants of health. EVAP frames this commitment within the context of immunization by establishing regional vaccination coverage targets that are higher than those of the Global Vaccine Action Plan so as to extend the benefits of immunization to wide sections of the population in the Region. It promotes a change in the way of working by tailoring immunization programmes to address inequities (EVAP objectives 2 and 3) and strengthening commitment to, and the programmatic and financial sustainability and functionality of, national immunization programmes (EVAP objectives 1, 4 and 5).

33. Based on the 2017 coverage estimates provided by Member States, the average regional coverage with the third dose of diphtheria-tetanus-pertussis vaccine (DTP3) at national level was 94%. Two Member States have shown substantive improvement in their coverage level, with Ukraine reporting DTP3 coverage of 50% in 2017 compared to 19% in 2016 and San Marino reporting DTP3 coverage of 85% in 2017 compared to 66% in 2016.

34. The number of Member States with ≥ 95% national DTP3 coverage decreased from 36 in 2014 to 31 in 2017, while the milestone for 2018 is 42 and the target for 2020 is 48. Of the 32 Member States which have provided subnational coverage data, only 19 have ≥ 90% DTP3 coverage in more than 90% of their districts in 2017. The 2020 target for this indicator is all 53 Member States.

35. The national DTP3 coverage estimates in the Region for 2017 show considerable variation in trends compared to 2016:

- ten Member States with coverage < 95% in 2016 showed an increase in coverage in 2017, of which three (Kazakhstan, San Marino and Ukraine) reported > 10% increase;
- four Member States with coverage < 95% in 2016 showed a steep decline (> 10%) in coverage in 2017. Of these, three (75%) are MICs.

36. Review of the available data also indicates inequities in immunization coverage within Member States, as indicated by wide variation in coverage levels between different administrative levels within countries and between socioeconomic groups. Such inequities exist even in Member States with high national coverage. However, not all Member States

systematically collect and report subnational data to enable assessment of inequities in immunization coverage and thereby allow comprehensive assessments of coverage inequities in the Region.

Goal 5: Make evidence-based decisions on introduction of new vaccines

37. EVAP holds Member States accountable for analysing available evidence, contextualizing the available evidence to the setting and making informed decisions on use of vaccines in the national immunization schedule, including introduction of new vaccines, by utilizing all available information, such as disease burden and cost-effectiveness data.

38. Member States have made significant progress in ensuring that mechanisms are in place to enable evidence-based decisions to be made with regard to the use of vaccines in national immunization schedules and new vaccine introduction. By 2017, national (independent) immunization technical advisory groups (NITAGs) had been established in 47 Member States.

39. These NITAGs provide recommendations to the health ministry on immunization policy and practice based on deliberate, comprehensive and evidence-based criteria, and empower governments to make informed decisions. Highly credible decisions can have a positive impact on perceptions about proposed adjustments to the immunization programme and can enhance the ability to secure funding, support from professional organizations, and acceptance from the public. A properly structured and well-functioning NITAG can resist the influence of different interest groups, including anti-vaccination lobbies, and increase public trust in immunization in general.

40. Following recommendations from NITAGs, an increasing number of Member States have taken advantage of the significant health gains offered by new and underutilized vaccines. By the close of 2017, 40 Member States had introduced pneumococcal vaccine (PCV), 37 had implemented human papillomavirus (HPV) vaccination, and 19 had started universal immunization with rotavirus vaccine, thereby helping to tackle diseases that threaten life at all ages, from pneumonia in infancy to cancer in adulthood.

41. An increasing number of Member States are also applying social science research to identify underserved population groups and their barriers to vaccination.

Goal 6: Achieve financial sustainability of national immunization programmes

42. Financial sustainability, in the context of national immunization programmes, is defined as the ability of a country to mobilize and efficiently use resources on a reliable basis to achieve current and future target levels of immunization programme performance in terms of access, quality, safety and equity.

43. By 2016, 47 Member States had achieved financial sustainability in procuring vaccines in their national immunization schedule using domestic funding. The Republic of Moldova gained its financial self-sufficiency in 2016 and started successfully funding all vaccines in its routine schedule from domestic resources. Armenia, Azerbaijan and Georgia followed in 2017, as they transitioned from donor support. Uzbekistan will be the next country to achieve

financial self-sufficiency during the life span of the existing EVAP, i.e. by 2020. Only Kyrgyzstan and Tajikistan will continue to receive donor support for procurement of vaccines beyond 2020.

44. Nevertheless, financial commitment to immunization is suboptimal in the Region. Member States facing the challenges of competing domestic priorities and inaccessibly priced vaccines on the global market experienced several vaccine shortages in 2015–2016, sometimes causing critical disruptions of services. Furthermore, to varying degrees, Member States face difficulties in sustaining programme performance, in part due to poorly understood issues related to programme access and vaccine hesitancy.

45. These issues are particularly acute in MICs, many of which self-procure vaccines and continue to face significant challenges in achieving financial sustainability of their immunization programmes. Evidence indicates that these Member States pay more for vaccines, have unstable vaccine supply and require support in securing and ring-fencing domestic funds for vaccines. All of these factors contribute significantly towards the declining trend in vaccination coverage in the south-eastern European MICs.

Middle-income country issues/challenges

46. The issues burdening immunization programmes in MICs extend beyond financial sustainability. In terms of protecting individuals against a greater number of vaccine-preventable diseases, by the close of 2016:

(a) five of the 14 MICs (36%) that do not benefit from donor support had not introduced rotavirus, pneumococcal conjugate or HPV vaccines, compared to only one of the 32 high-income countries (3%);

(b) all seven MICs that benefit from donor support had introduced one or more of these vaccines.

47. In terms of protecting more individuals against vaccine-preventable diseases targeted by their current national immunization schedules, by the close of 2016:

(a) average coverage of DTP3 in MICs with no donor support is 88.7%, versus a regional average of 93.3%;

(b) average coverage with first dose of measles-containing vaccine in MICs with no donor support is 91.8%, versus a regional average of 93.6%.

48. In terms of achieving elimination and control of diseases, by the close of 2016:

(a) MICs with no donor support represented 56% of the measles and rubella endemic Member States in the Region;

(b) thirteen MICs with no donor support out of 53 Member States in the Region accommodated 70% of infants unvaccinated with DTP3.

49. Considering the current level of performance and the target population represented by the MICs with no donor support in the Region, it is likely that they will have a substantial influence on the outcome of the regional targets outlined in EVAP to be met by 2020. Furthermore, inequities in these Member States are likely to have a significant influence on regional efforts to reduce the inequities in the Region unless comprehensive action is taken.

Midterm review conclusions

50. The midterm review report concludes that political commitment remains essential for optimizing the performance and impact of immunization programmes in every country in the Region. It is of paramount importance that such political commitment by Member States is translated into country-specific operational activities. Through such demonstrable commitment, Member States recognize the vital importance of vaccination as a critical public health intervention and a public good, and acknowledge the value that immunization brings in terms of health, social and economic returns.

51. The declining trend in vaccination coverage in the south-eastern part of the Region is of particular concern and needs to be addressed. The review report recommends amplification of political advocacy and support to MICs in developing a cohesive strategy that systematically addresses the specific subregional challenges that some of these Member States face. The review notes that the Regional Office, with the support and engagement of its Regional Director, has already laid the foundation for this work and successfully secured political buy-in for the development and implementation of an MIC roadmap in the Region.

52. The report notes that while the Region has so far maintained its polio-free status, a number of Member States remain at intermediate or high risk for sustained transmission following importation of polioviruses. All Member States will need to enhance and/or sustain high vaccination coverage to maintain high population immunity and sustain high quality surveillance to respond promptly in case of importation or re-emergence of the virus. Member States with PEFs will also need to maintain a high level of vigilance to avoid breaches in containment and mitigate the risk of spread, should a breach occur.

53. While the Region has made considerable progress towards measles and rubella elimination, the midterm review concludes that the Region is not on track to achieve elimination by 2020. A sustained and strong political commitment will be required to achieve this elimination goal. The gaps in the extent and quality of surveillance required to verify elimination, addressing pockets of vulnerable unvaccinated/under-vaccinated population and mitigating risks caused by movements of migrants and refugees from populations with low immunity levels are challenges that need to be overcome to achieve this goal on time.

54. Currently, 13 Member States in the Region schedule their second dose of measles-containing vaccine after the age of six years and many more provide this dose at six years. In line with recent evidence on population-mixing patterns and risk of measles transmission, these Member States should consider reviewing their measles vaccination schedules and epidemiological and coverage data, and consider optimizing the age of immunization to maximize disease control.

55. At this stage of progress towards measles and rubella elimination in the Region, the ability to distinguish between endemic and import-related transmission will be crucial to the verification process. The availability of genotyping data is an important element in this determination. The Member States in the Region should ensure improved reporting of genomic sequence data for both measles and rubella.

56. With regard to controlling hepatitis B, the midterm review report notes the guidelines developed by the Regional Office with the guidance of an ETAGE working group, which will also review the country reports to validate the achievement of agreed targets. Systematically

collected data from well-designed serosurveys may be helpful to document the impact of vaccination and the achievement of the hepatitis B control goals and targets. However, it is likely that given the time taken to collect data, the formal validations by the ETAGE Working Group of achievement of the targets in each of the 53 Member States and thereafter at the regional level will only be completed after the target year of 2020.

57. The midterm review report notes the wide variation in vaccination coverage both between Member States and also between and within their subnational administrative levels. Member States need to prioritize identification of the geographical areas of suboptimal performance, and unvaccinated and/or under-vaccinated population subgroups, and develop innovative strategies to ensure that the agreed vaccination targets in EVAP are achieved.

58. With an increasing number of Member States in the Region demonstrating financial sustainability in procuring vaccines using domestic funding, the midterm review report outlines the need to further strengthen immunization financing, by developing new, innovative financing mechanisms and enhancing resource mobilization to sustain the financial resources needed to achieve the expanding objectives of national immunization programmes. In view of the challenges identified in the MICs in the Region, a cohesive and systematic approach will be required to move towards greater financial self-sufficiency in the funding of both vaccines and essential services of national immunization programmes, especially in the MICs.

59. In order to justify appropriate investment in the immunization programmes, and ensure that the necessary changes are made to national immunization schedules (including decisions to introduce new vaccines), an increasing number of Member States are ensuring evidence-based decision-making through comprehensive use of disease burden information with better analysis of immunization programme and vaccine-preventable disease surveillance data. The review report notes the need to further strengthen the capacities of national immunization technical advisory groups in the Region.

60. All national immunization programmes should be aware that equity issues may be affecting their progress towards the regionally agreed immunization targets and must be considered when developing immunization strategies and policies. Nearly all Member States, but particularly those currently lagging behind, can improve immunization coverage by ensuring that their programmes are more equitable. Equitable immunization policies, like all equitable health policies, are needed to generate wider health, social, political and economic benefits. As a result, improving equity in immunization can also improve coverage of other related health interventions. Even with existing differences in coverage, immunization has wide access to the population and is a powerful platform for attracting people into health care, especially the most vulnerable, who often have worse access to health care and are more vulnerable to disease.

61. The midterm evaluation recommends that Member States:

(a) identify inequities in immunization coverage, develop tailored and innovative strategies to reach unvaccinated and under-vaccinated populations, and extend the benefits of new vaccines to all ages and sections of the population;

(b) establish and implement policies and strategies for ensuring operational and financial sustainability and efficiency of immunization programmes, including establishing and further strengthening the capacity of national decision-making bodies;

(c) strengthen vaccine-preventable disease surveillance (including rotavirus and invasive bacterial vaccine-preventable disease surveillance) to monitor emerging and/or re-emerging vaccine-preventable diseases, generate evidence to inform decisions to introduce new vaccines, document their impact and allow verification or validation of regional elimination and disease control goals;

(d) develop/adapt strategies to improve the quality of immunization programme and disease surveillance data to facilitate the decision-making process and ensure inclusiveness in the use of such data.

The role of the WHO Regional Office for Europe

62. WHO led and facilitated the development and implementation of EVAP. WHO has also advocated for the new course set by EVAP that aims to empower immunization programmes through new and ambitious strategies to ensure that these programmes are financially sustainable and anchored in well-functioning health systems. WHO, through the EVAP development process and since, is acknowledged as having particularly emphasized the importance of equitable access to vaccination. WHO's convening of immunization partners and stakeholders through the first half of EVAP's life-span has helped national immunization programmes to strengthen and align their immunization policies, implementation and monitoring accordingly.

63. Since EVAP's launch, support from the Regional Office to national immunization programmes has included price transparency projects, vaccine safety management and communications capacity building; resource mobilization tool development; dissemination of information and training with a view to securing domestic financing of immunization programmes; and capacity building on issues related to vaccine demand, particularly in relation to behavioural insights and tailoring programmes to increase vaccination coverage. Furthermore, recognizing the need at country level to prepare for and mitigate potential crises in confidence, the Regional Office has developed a comprehensive vaccination and trust library and training package.

64. The Regional Office also continues to support Member States in strengthening capacity in vaccine procurement, vaccine cold chain and immunization logistics, injection safety and waste management, causality assessment methodology, cold chain upgrades and evaluations, laboratory accreditation and training on contraindications as part of the holistic improvement of immunization service delivery.

65. European Immunization Week has been actively utilized by national health authorities and civil society throughout the Region. All 53 Member States have celebrated the Week since 2013. Its visibility and reach on social media is particularly far-reaching, demonstrating the commitment of Member States to using this event in ever-evolving ways to advocate the importance of immunization among various stakeholders, including parents of unimmunized children.

The role of partners

66. EVAP is the operational framework for the Vaccine-preventable Diseases and Immunization programme of the Regional Office and for the immunization partners operating

in the Region. Country actions and initiatives targeting EVAP objectives are technically supported and complemented by the activities of the Region's immunization partners and donors.

67. The contributions of national and regional partners are vital to ensuring that a shared approach is adopted and that efforts to protect the health of individuals are optimized. Important partners for Member States include the United Nations Children's Fund, the European Union and its institutions (for example, the European Centre for Disease Prevention and Control), bilateral development agencies, academic institutions, WHO collaborating centres, professional associations and civil society and nongovernmental organizations.

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